FORSCOM ARMS GUIDE
J-Aviation Medicine
VERSION 10, EFFECTIVE 1 OCTOBER 2005

A-COMMAND FACTORS

QUESTION QUESTION TEXT REFERENCE TEXT INSPECTION TECHNIQUE

*1.00

Are corrective actions taken on deficiencies noted on previous evaluations of the aviation medicine program? (AR 1-201, para 2-2e) (AU)

2-2e. Followed up. Inspections expend valuable resources and are not complete unless the inspecting unit or agency develops and executes a follow-up inspection or plan to ensure the implementation of corrective actions. Likewise, the inspected unit must develop and execute a corrective-action plan that fixes those problem areas identified during an inspection. Follow-up actions can include re-inspections, telephone calls (or visits) to units or proponents to check on the progress of corrective actions, or a request for a formal response from a unit or proponent that attests to the completion of the corrective action. To reduce the administrative burden on inspected units, a formal response to inspection reports is optional unless specifically requested.

Identify discrepancies rated as UNSAT during the last ARMS or previous AAPS. Determine if the last discrepancies are currently corrected. Ensure at least 70% of past ARMS discrepancies are currently rated satisfactory

2.00

Does the flight surgeon conduct aviation accident prevention surveys (AAPS) in the area of aviation medicine and **keep** them on file? (AR 40-3 Para. 3-6b (6)), AR 385-95 Para. 3-2(AU)

Para 3-6b (6) Conduct a semiannual accident prevention survey of the AVMED Program as required by AR 385–95. AR 385-95 Para. 3-2 a. Commanders of all active component aviation units and reserve component aviation support facilities will conduct AAPSs semiannually, at a minimum. Commanders of all other units will conduct AAPSs annually, at a minimum. “Guide to Aviation Resource Management for Aircraft Mishap Prevention” or a similar guide should be used as a reference. When possible, the AAPS should be administered from the battalion/squadron level consolidating the safety staff into a survey team and using supplemental expertise from outside the unit. b. Surveys conducted by external sources (brigade, installation, or MACOM aviation resource management surveys; standard Army safety and occupational health inspections; regional accident prevention surveys) may count toward semiannual accident- prevention surveys, provided all applicable functional areas for the organization are surveyed. An external survey may count toward the annual requirement for Reserve component units. The AAPS may be concurrent with internal command inspection programs as long as all unit functional areas are surveyed. c.The AAPS is a major source in the hazard identification step of the risk management process.

Review documentation from the last five years’ AAPS. Ensure that Aviation Medicine was surveyed and documented at least semi-annually (Active Component) or annually (Reserve Component) in each of the last five years.

*3.00

Are hazards found during the AAPS, in the area of aviation medicine, listed on the unit’s hazard-tracking system? (AR 385-95, Para. 3-2c) (AU)

Para. 3-2c The AAPS is a major source in the hazard identification step of the risk management process. All hazards identified during the AAPS must be thoroughly assessed for their risk level, and control options must be developed for command decision-making and implementation. Hazards found during the AAPS will be tracked through the unit hazard tracking system.

Verify that discrepancies noted in the area of Aviation Medicine during the last five years' AAPS are incorporated into the unit's hazard tracking system.

*4.00

Are the authorized number of flight surgeons assigned (authorized and required) IAW AR 616-110, para 11, a, b. If not, is the shortage listed on the USR? (AR 220-1) (AU)

Para. 11. The role of Army Aviation Medicine is to support Army aviation's mission. Flight surgeon requirements are determined by the number of aviation personnel supported, with the ratio of 250 aviation personnel per one flight surgeon generally not to be exceeded. Aviation personnel include individuals on operational and non-operational status within the area supported by the flight surgeon. Variables such as size, number, and location of units supported, frequency of deployment, mission requirements, and area support requirements may increase the number of flight surgeons required to conduct the Aviation Medicine Program. Questionable cases will be submitted for review by TSG (HSXY-AER) or the Chief, National Guard Bureau (ARNG-OAC). a. Flight surgeons are required in the table of organization and equipment (TOE) of aviation battalions or squadrons and larger units to provide advice on medical matters to the commanders and to provide medical treatment for assigned unit personnel. b. Flight surgeons, SSI 61N, are required in tables of distribution and allowances (TDA) as follows: (1) Medical section of headquarters elements at installations which provide medical support for Army aviation operations, regardless of size. (2) Staff sections of major command headquarters in the position of aviation medicine consultant. (3) Faculty positions at selected U.S. Army schools. (4) Staff positions at selected U.S. Army medical research and development activities. (5) Staff positions in selected Department of Army supervised activities. (6) Staff positions in the Office of The Surgeon General (TSG), Department of the Army. (7) Clinical positions in medical treatment facilities for the purpose of providing aero medical consultation and/or aviation medicine support.

Review the unit manning roster and MTOE to determine if authorized Flight Surgeons are assigned. If they are not, ensure that the shortage is reflected in the unit manning roster and in the unit status report. If units are not authorized a FS, this question is not applicable and question 5.00 below is.

5.00

In units without an authorized or assigned flight surgeon, do the local medical treatment facility (MTF) Commander and the Command Surgeon (MACOM, USARC or State Surgeon) provide personnel and equipment for the Army Aviation Medicine Program at the local level? (AR 385-95, Para. 1-6g, AR 616-110, Para. 12b) (AU)

Para. 1.6. g. Flight surgeon. The flight surgeon assists and advises the command in all aviation medical matters. In remote areas where a flight surgeon is not assigned or readily available, local support will be provided by the servicing medical department activity (MEDDAC) to best accomplish these duties. The flight surgeon will; (1) Maintain liaison within the command to implement the aviation medicine program. (2) Take part in, and observe, flight operations to monitor the interactions of crewmembers, aircraft, and environment. The flight surgeon exerts maximum effort in observing the flying ability and characteristics of each assigned aviator at least annually. (3) Serve as a member of aircraft accident investigations board, when directed. (4) Serve as a member of flight evaluation boards, when directed. (5) Ensure that the medical portion of the pre-accident plan is adequate. (6) Monitor the physical and mental health of aviation personnel, including alcohol abuse and self-medication problems, and advise the commander on crew-endurance issues. (7) Maintain aviation medical records on flight personnel, assist the unit in providing annual occupational health and safety screening for non-crewmember personnel, and ensure that DA Form 4186 (Medical Recommendation for Flying Duty) prepared on flight personnel is accurate and complete prior to being sent to the unit commander for approval. (8) Monitor the

survival and physiological training of aviation crewmembers and provide medical support in accordance with applicable Army regulations. (9) Medically clear crewmembers for further flight duty after aircraft accidents in accordance with applicable Army regulations. (10) Make recommendations to the Commander, USASC, for improvement of human factors compatibility, crashworthiness, aviation life-support equipment, and survival features of aircraft. (11) Take part in aviation safety meetings to educate aviation crewmembers on the aeromedical aspects of flight. (12) Monitor the ALSE program. (13) Assist in, and advise on, the hearing and occupational vision program. (14) Ensure command consideration of preventive and occupational medicine aspects of all plans, operations, training, and security missions. . (AR 616-110 para 12b) *b.* Other duties will not jeopardize the primary aviation medicine effort. Flight surgeons should not be utilized in other medical activities when fulltime application to aviation medicine is required to meet local aviation medicine requirements. (This is not an exemption for all flight surgeons from other medical activities.)

Check to see if aviation medicine program requirements are being met without an assigned flight surgeon. Verify that each one of the 14 Flight Surgeon responsibilities listed in AR 385-95, paragraph 1-6g is being satisfied. At least 70% of the requirements listed in AR 385-95 paragraph 1.6. G must be satisfied to receive a SAT for this question.

*6.00

Does the commander suspend pay for non-rated crewmembers with overdue flight physicals (Flying Duty Medical Examinations (FDME's)) and administratively suspend these crewmembers from flying duty? (AR 600-106, Para. 2-7(2)) (AU)

Para. 2-7 (2) Soldiers who have not had a current valid medical examination as stated in AR 40–501 will be automatically suspended from flying status. The suspension will be effective on the date their medical examination expires. Commanders will notify the servicing Finance and Accounting Office when non-rated Army aviation personnel have been suspended from flying status.

Check for overdue flight physicals of non-rated personnel. Verify through Flight Operations that non-rated crewmembers with expired flight physicals have been suspended from flight duties (DA Form 4186) and review documentation verifying that the Finance and Accounting Office has been notified.

7.00
Does the Flight Surgeon or unit track FDMEs from initiation until posted in the Health Record with a final disposition from USAAMA? (AR 40-501, para 6-10f) (AU)

6-10f. Tracking. The flight surgeon or aviation unit will track FDMEs from initiation until posted in the health record with a final disposition by USAAMA. If disqualified, the flight surgeon and aviation unit will take action as per AR 600–105.

Check for unit or FS office procedures (SOP or other documentation of procedures) to assure FDMEs are tracked. Procedures must ensure that the medical status of individual crewmembers is tracked either by the either unit or FS. Unit procedures must ensure that FDMEs are tracked to and from AAMA (for class 1, 2 and 4 qualification) and back into the Health Records. Verify effectiveness of procedures by checking Health Records for the filing of AAMA qualified FDMEs and the Aeromedical Electronic Records Office (AERO) for AAMA qualification of the FDMEs.

8.00

Are procedures in place whereby air crewmembers are automatically grounded when treated in an emergency center or specialty clinic? (AR 40-3, para 3-5d (3)) (AU)

3-5d. Aeromedical consultation. The FS will—(1) Ensure that an on-call service for aeromedical emergencies and aeromedical evacuation consultations is in place during all hours of flight operations. (2) Interview newly assigned aviation personnel and review their medical records before granting a medical clearance to fly. (3) Establish procedures whereby air crewmembers are automatically grounded when treated in the

emergency center (EC) or specialty clinic. Protocols should then require grounded air crewmembers to report to the FS as soon as reasonably possible.

Check for written procedures to automatically ground crewmembers when they receive emergency treatment. Verify existence of procedures by reviewing SOPs, memorandums for record, reading files, or aeromedical classes concerning non-flight surgeon treatment.

*9.00

Are rated crewmembers administratively restricted (grounded) from flying duties and considered for a non medical disqualification (DQ) and Flight Evaluation Board when the DA Form 4186 (upslip) or Flying Duty Medical Examination (FDME) expires? (AR 600-105, Para. 6-1(2)) (AU)

Para. 6-1(2) Failure to maintain medical certification. All officers, regardless of component or whether or not assigned to operational flying duty assignments must maintain medical certification for flying duty through timely physical examinations (AR 40–501). If the certification expires, the officer is unfit until medically qualified or a temporary medical extension is provided. Aviation service is suspended effective the day following the last day of his or her birth month. In cases where temporary medical extension has been provided, aviation service is suspended on the first day following the last day of the extension. The immediate commander will temporarily suspend the officer from flying duty. (a) If not physically examined and medically recertified within 180 days following the date of suspension, the proper appointing authority will convene an FEB. (b) If the officer is given a physical examination within 6 months of suspension and the examination shows that the officer is unfit and will not be fit by the 181st day following suspension, the flight surgeon will inform the commander and USAAMC. USAAMC will act on the medical report. If disqualification is recommended, CDR, PERSCOM or CNGB will publish an aviation service order disqualifying the officer from aviation service. The effective date of this action will be the 181st day following suspension. (c) Officers must plan for timely completion of their physical examination and medical recertification. They must consider additional time for processing medical waivers. When an officer is stationed in a remote area and only limited facilities are available, or when other unexpected circumstances prevent a timely physical examination and medical recertification, an officer may request extension of eligibility up to 6 months as an exception. The officer will send a memorandum through his or her commander to the FEB appointing authority. The FEB appointing authority approves or disapproves the request.

Check for expired DA Forms 4186 (upslips) in the IFRF. Check for overdue flight physicals in the Health Records or through AERO. Ensure that rated crewmembers with expired upslips or FDMEs are identified and grounded (DA Form 4186). Ensure that officers with FDMEs expired for over 180 days are scheduled for an FEB.

*10.00

Are Department of the Army Civilian (DAC) pilots, contract pilots, civilian Air Traffic Control (ATC) personnel, and Wage Grade 11 (WG-11) personnel maintaining valid Army Flying Duty Medical Examinations (FMDEs)? (AR 40-501, Para. 4-2) (AU)

4–2. Classes of medical standards for flying and applicability The classes of medical fitness standards for flying duties are as follows: *a.* Class 1 (warrant officer candidate) or Class 1A (commissioned officer or cadet) standards apply to— (1) Applicants for aviator training. (See also AR 611–85 and AR 611–110.) (2) Applicants for special flight training programs directed by DA or NGB, such as Army ROTC or USMA flight training programs. (3) Other non-U.S. Army personnel selected for training until the beginning of training at aircraft controls, or as determined by Chief, Army Aviation Branch. *b.* Class 2 standards apply to— (1) Student aviators after beginning training at aircraft controls or as determined by Chief, Army Aviation Branch. (2) Rated Army aviators (AR 600–105). (3) DAC pilots and contract civilian pilots who are employed by firms under contract to the DA that conduct flight operations or training, utilizing Army aircraft or aircraft leased by the Army. (See para 4–31.) (4) Army aviators considered for return to aviation service. (5) Senior career officers. When directed by DA or NGB under special procurement programs for initial Army aviation flight training, selected senior officers of the Army may be medically qualified under Army Class 2 medical standards. (6) Applicants to DA or NGB civilian-acquired aeronautical skills programs. (7) Other non-U.S. Army personnel. *c.* Class 2F standards apply to— (1) FSs (AR 600–105) and APAs. (2) Medical officers, medical students, and physician assistants applying for or enrolled in the Army Flight Surgeon's Primary Course or Army Aviation Medicine Orientation Course. *d.* Class 3 standards apply to non–rated (AR 600–106) soldiers and civilians ordered by a competent authority to

participate in regular flights in Army aircraft, but who do not operate aircraft flight controls. These include crew chiefs, aviation maintenance technicians, aerial observers, gunners; unmanned aerial vehicle operators (UAVO), nonrated (AR 600–106) medical personnel selected for aeromedical training, such as flight medical aidmen, psychologists, dentists, and optometrists; and others. (See para 4–32.) *e.* Class 4 standards apply to Army military ATCs. (See paragraph 4-33*b* for standards for Army military ATCs. See paragraph 4–33*a* for the standards that apply to DAC ATCs and civilian ATCs employed under contract by DA or by firms under contract to DA.)

Check to ensure all applicable personnel maintain a current FMDE through DA Forms 4186 in the IFRF, FDMEs in the Health Records, or VFSO. In the case of contract personnel, ensure that the COR verifies that personnel required to receive Army FDMEs are receiving them.

11.00

Are non-operational aviators completing annual flight physicals? (AR 600-105, Para. 3-1, c) (AU)

Para. 3-1, c All aviators and flight surgeons, whether or not assigned to operational flying duty positions, must meet class 2 medical fitness standards for aviators and class 2F medical fitness standards for flight surgeons for flying duty (AR 40–501) and be issued a medical clearance on DA Form 4186, Medical Recommendation for Flying Duty. Flight surgeons who resigned from aviation service (AR 616–110) or who have been terminated from aviation service by TSG; CDR, ARPERCEN; or CNGB, are not required to maintain class 2F medical certification.

Check to ensure all non-operational aviators whose IFRFs are maintained by the inspected unit maintain a current FMDE in the Health Record and DA Form 4186 (upslip) in the IFRF.

*12.00

Do individual Flight Records contain the required DA Form 4186 (medical clearance for flying or medical restriction from flying) and are they completed correctly? (AR 40-501, Para. 6-11,d) (AU)

Para. 6-11d. Each item of the DA Form 4186 will be completed as directed by the Commander, USAAMC. Three copies of the DA Form 4186 will be completed. … Copy 2 is forwarded to the examinee's unit commander who signs and forwards it to the flight operations officer for inclusion in the flight records (AR 95–1 and FM 1–300). Copy 3 is given to the examinee

Check IFRFs for assigned crew members. Verify that all required DA Forms 4186 are maintained in the IFRF and that all blocks are filled out appropriately.

13.00

Do individual Flight Records contain applicable medical waiver recommendations and approval letters? (AR 40-501, para 6-10g) (AU)

g. Disposal of documentation. Waiver and suspension recommendation and approval letters will be filed in the individual health record and flight record.

Check records for applicable waivers and approval letters. Waivers printed from AERO with "Waiver Granted" will suffice in lieu of waiver request and approval letters.

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14.00

Are extensions granted for flight physicals prior to the expiration date of the current physical? (AR 40-501, Para. 6-11, i) (AU)

Para. 6-11, i. The validity period of the current FDME may be extended for a period **of one calendar month beyond the birth month** on DA Form 4186. After expiration of this extension, the aircrew member or ATC must complete the FDME and be medically qualified or be: (1) administratively restricted from flying duties if no aero medical DQ exists and be considered for a non–medical DQ and FEB. (2) Medically restricted from flying duties if an aero medical DQ exists. In some cases, temporary flying duties may be recommended on DA Form 4186.

Check extensions for correct dates. Ensure extensions are granted before the end of the birth month. Ensure that extensions granted under the 120 day rule are correctly documented per the 21 March 2003 Surgeon General's policy letter concerning Operational Aeromedical Administration.

*15.00

Are crewmembers performing aviation duties with expired physicals or extensions? (AR 95-1, Para. 2-1b; AR 40-501 Para. 6-11i) (AU)

Para. 2-1b. All Army aviators who are in aviation service per AR 600-105 must meet the annual physical requirements of AR 40-501 regardless of assignment. AR 40-501 Para. 6-11i. The validity period of the current FDME may be extended for a period not to exceed 30 days on DA Form 4186. After expiration of this extension, the aircrew member or ATC must complete the FDME and be medically qualified or be— (1) Administratively restricted from flying duties if no aero medical DQ exists and be considered for a non–medical DQ and FEB (AR 600–105). (2) Medically restricted from flying duties if an aero medical DQ exists. In some cases, temporary flying duties may be recommended on DA Form 4186

Look for expired FDMEs in the Health Records and in AERO. Use the DA Form 2408-12 print out from Flight Operations to determine if crewmembers performed flight duties while not medically qualified. One discrepancy in this area results in an UNSAT for the question.

16.00

Does the unit's aero medical training program comply with the following references? (AR 95-1 Para. 4-14, 8-1g, AR 385-95, Para. 1-6g(11), FM 3-04.301, Chance 1, Para. 1-9,1-10, 1-11) (AU)

Para. 4–14 Flight crew members will receive aero medical and low pressure/high altitude training per the appropriate ATM and TC 1-210. para 8-1g. Flight surgeons and aero medical advisors are responsible for— (1) Physiological training of aircrew personnel. (2) Medical aspects of survival training of aircrew personnel. (3) Monitoring the fitting and use of ALSE by aircrew personnel. AR 385-95 1-6g. Flight surgeon. The flight surgeon assists and advises the command in all aviation medical matters. In remote areas where a flight surgeon is not assigned or readily available, local support will be provided by the servicing medical department activity (MEDDAC) to best accomplish these duties. The flight surgeon will:… (11) Take part in aviation safety meetings to educate aviation crewmembers on the aero medical aspects of flight. **FM 3-04.301 Para 1-9, CONTINUATION TRAINING. The requirement for continuous training applies to all U.S. Army aircrew members in operational flying positions. The POI must be conducted once a year. The following subjects are the minimum training necessary for the unit to obtain adequate safety and efficiency in an aviation environment: altitude physiology, spatial disorientation, aviation protective equipment, and stress, fatigue and exogenous factors. Para** 1-10, **MISSION CONSIDERATIONS**. The unit commander must evaluate the missions of the unit to **incorporate mission considerations into the aeromedical training POI**. This analysis should include the following: Combat mission. Installation support missions. **Contingency missions. Geographic and climatic considerations** Programmed training activities. 1-11. The supporting flight surgeon will help identify the aero medical factors present during the various flight conditions and their effect on aircrews' performance. The flight surgeon and the unit commander will then develop a POI that meets the specific needs of the unit. 1-12. Commanders will include all crew members in the unit aero medical training program

Check to ensure appropriate aeromedical training is conducted in the organization by verifying sign-in rosters, training schedules, lesson plans, and SOPs. Check to ensure that the unit establishes an effective make up training program.

17.00

Has a mission analysis been conducted to determine special aero medical training requirements? (FM 3-04.301, Para. 1-10) (AU)

Para. 1-10. The unit commander must evaluate the missions of the unit to determine its special aero medical training requirements. This analysis should include the following; Combat mission. Installation support missions. Contingency missions. Geographic and climatic considerations. Programmed training activities.

Check for documentation indicating a mission analysis has been conducted to determine training requirements. Documentation includes, but is not limited to, memorandums for record, meeting minutes, proof of aeromedical training planned or conducted that is not specifically required by regulation or training circular.

18.00

Do aircrew members and DOD civilians who fly in pressurized aircraft or in aircraft that routinely exceed 10,000 ft MSL receive hypobaric training? (FM 3-04.301, para 1-3) (AU)

1-3. Crew members and Department of the Army civilians who fly in pressurized aircraft or in aircraft that routinely exceed 10,000 feet MSL **supplemental oxygen must complete aeromedical refresher training to include participation in a hypobaric chamber (Type IV Profile) every five (5) years…Aircrew members with 240 months of TOFDC and 4 successful altitude chamber iterations must complete classroom training requirements but are exempt from the altitude chamber and rapid decompression practical exercise requirements**

Verify unit mission profile and equipment to determine if altitude training is required. Check applicable records for the required training certificates.

19.00

Does the Flight Surgeon assist the unit Aircrew Life Support Equipment shop with Class VIII support and survival education? (AR 95-1, Para 8-1g, AR 40-3, para 3-5b (3)) (AU)

Para 8-1g. Flight surgeons and aeromedical advisors are responsible for (1) Physiological training of aircrew personnel and (2) medical aspects of survival training of aircrew personnel. Para 3-5b (3) Assist unit Aircrew Life Support Equipment shop with Class VIII support and survival education.

Check for evidence that the flight surgeon has visited the ALSE Shop and assisted in training requirements and class VIII support.

20.00

Is the supporting flight surgeon a member of the Safety Council? (AR 385-95 Para. 3-4b) (AU)

Para. 3-4b. The CSC is organized by the ASO, chaired by the commander, and consists of the following unit personnel (if assigned), at a minimum: (1) Commander. (2) Operations officer (S-3). (3) Instructor pilot/standardization instructor pilot (IP/SP). (4) ASO. (5) Aviation maintenance officer. (6) ALSS manager. (7) Flight surgeon. (8) Senior unit NCO (1SG/CSM). (9) Aviation safety NCO (ASNCO). (10) Other personnel designated by the commander, as required.

Check council appointments and flight surgeon participation in the safety council meetings. Participation is verified by ensuring that the FS was present at the council meeting or by reviewing documentation showing that the FS reviewed council minutes.

21.00

Does the supporting flight surgeon take part in safety meetings and training? (AR 385-95, Para. 1-6g (11), AR 40-3, Para. 3-6 (2) (3) (5)) (AU)

AR 385-95, Para. 1-6g (11) Take part in aviation safety meetings to educate aviation crewmembers on the aero medical aspects of flight.
AR 40-3, Para. 3-6 (2)(3)(5) (2) Conduct aero medical briefings held for both officer and enlisted personnel at unit-level training or aviation safety meetings. (3) Participate in aircraft mishap exercises and observe the effectiveness of response, equipment, and communication of fire rescue, air ambulance, and medical teams. The FS will develop and periodically review the medical portion of the unit's pre-accident plan as described in AR 385–95 and AR 40–21. (5) Participate in unit field training exercises and unit day-to-day flight activities.

Check training documentation for flight surgeon participation. Participation in training includes attendance and training conducted by the FS at the safety training events. Participation in safety meetings includes documentation showing the FS present at the meeting or review of the meeting minutes.

22.00

Are the flight surgeon and or aviation physician's assistant incorporated **into** a local unit Reading File? (AR 95-1, Para. 4-4) (AU)

Para. 4–4. Aircrew information reading files: Aviation units will establish and maintain aircrew training and information reading files per AR 385 - 95 and TC 1 – 210. Assigned aircrew personnel will read and remain familiar with these files.

Check for evidence that the assigned medical personnel are included into reading files. The FS must be incorporated into a local reading file. For example, if a FS is assigned to and primarily flies with the 214th AVN BN, but also supports other units at the local airfield or AASF, the FS must at a minimum be integrated into the 214th AVN BN's reading file. If that FS also flies with units at another airfield or AASF, the FS must be integrated into those reading files in addition to the 214th AVN BN's reading file.

23.00

Are the supporting flight surgeon and or aviation physician's assistant on flight status with valid orders issued by the appropriate agency? (AR 600-105, Para. 3-9 and AR 600-106, Para. 2-2a (1) and (3)) (AU)

Para. 3–9. Operational flying duty for flight surgeons a. Flight surgeons are considered on operational flying duty when placed on aviation service orders by TSG, CDR, ARPERCEN or CNGB. This duty entitles them to monthly Aviation Career Incentive Pay (ACIP). **AR 600-106, Para 2-2a (1) For the soldiers who meet the requirements of paragraphs 2-3, 2-4, and 2-5: Active Army major command (MACOM) commanding generals, commanders of continental United States (CONUS) installations, and the state Adjutants General…(3) For Aeromedical Physician's Assistants: The Surgeon General (DASG-PTZ), 5111 Leesburg Pike, Falls Church, VA 22041 or for ARNGUS – State Adjutant General.**

Check for current flight status orders in the supporting Flight Surgeon's or APA's IFRF.

24.00

Does the flight surgeon and / or aviation physician's assistant meet the minimum flying hour requirements? (AR 600-105, Para. 3-10) (AU)

Para. 3–10. Flight surgeons annual minimum flying hours a. Flight surgeons assigned to flying duty must be credited a minimum of 4 hours per month in any military aircraft for active duty and 2 hours per month for RC to qualify for monthly ACIP (DODPM, part two). Rules pertaining to the banking of hours apply. Table 3–4 defines minimum hourly requirements for flight surgeons. b. Semiannual and annual minimum requirements will be reduced proportionately for those who begin or end flying during a certain flying year.

Check flight records to determine if assigned flight medical personnel met minimum requirements.

25.00

Does the Flight Surgeon participate as an air crewmember in each type of aircraft assigned to supported units? (AR 40-3, para 3-6f (6), AR 600-105, para 3-10d) (AU)

(6) Participate in an operational capacity as an air crewmember in flight in each type of aircraft assigned to supported units. An FS's operational capacity will include observing flight crewmembers, monitoring patients, etc. Flight will be in all flight environments—including emergency procedures—and mission profiles (for example, nap of the earth, night vision goggles, etc.) according to AR 95–1 and AR 600–105. Flight simulators should be used in units that cannot accommodate an FS as a crewmember due to training and qualification requirements (for example, those with attack and scout aircraft). The purpose of this simulator time is to ensure that FSs understand the mission profiles and stresses of the aviators that they support. Flight simulator time does not count toward meeting the aviation career incentive pay (ACIP) flying hour requirement. **AR 600-105, para 3-10d. Flight Surgeons are considered essential aircrew and are expected to fly (1) primarily with the unit(s) they support. (2) In all types of military aircraft and mission profiles in their units…**

Check for flight surgeon participation as a crewmember in all types of military aircraft and mission profiles in their units or in units that they support.

26.00

Does the Pre-accident plan address the duties and responsibilities of the flight surgeon? (AR 385-95, Para. 1-6g (5), AR 40-3 Para 3-6.f(3)) (AU)

Para. 1-6g (5) Ensure that the medical portion of the pre-accident plan is adequate. AR 40-3 Para 3-6.f(3) Participate in aircraft mishap exercises and observe the effectiveness of response, equipment, and communication of fire rescue, air ambulance, and medical teams. The FS will develop and periodically review the medical portion of the unit's pre-accident plan as described in AR 385–95 and AR 40–21.

Check flight surgeon responsibilities in the pre-accident plan. Ensure duties are clearly identified.

27.00

Does the Flight Surgeon develop and periodically review the medical portion of the unit's Pre-accident plan as described in AR 385-95 and AR 40-21? (AR 40-3, 3-6f(3)) (AU)

(3) Participate in aircraft mishap exercises and observe the effectiveness of response, equipment, and communication of fire rescue, air ambulance, and medical teams. The FS will develop and periodically review the medical portion of the unit's pre-accident plan as described in AR 385–95 and AR 40–21.

Check flight surgeon involvement in developing the pre-accident plan.

28.00

For units with assigned medics (91W) is SACMS-VT (Semi-annual Combat Medical Skills Validation Test) administered at least twice a year with a minimum of four months between record events? (TC 8-800, preface) (AU)

The Army Surgeon General has directed that all 91W's, Health Care Specialists must validate skills proficiency semi-annually. Therefore SACMS-VT will be administered at least twice a year, with a minimum of 4 months separating record events. Commanders may administer SACMS-VT more than twice a year, but they must indicate beforehand when results are intended for record purposes.

Check for completion of validation test. Ensure recorded events are at least 4 months apart.

29.00

Are all 91W military occupational specialty (MOS) recertifying in accordance with National Registry of Emergency Medical Technicians guidance? (AR 40-68, para 4-3a (2)) (AU)

(2) In specialties that are not licensed by the State, and the requirements of the granting authority for State registration or certification are highly variable, there must be validation by a national organization that the individual is professionally qualified to provide health care in a specified discipline. Examples of this are the National Commission on the Certification of Physicians Assistants (NCCPA) for physician assistants (PAs) and the National Registry of Emergency Medical Technicians (NREMT) for emergency medical technicians.

Check for NREMT certification on all assigned 91Ws. This can be verified using certification documents or using MODS.

B- CLINICAL DUTIES

QUESTION QUESTION TEXT REFERENCE TEXT INSPECTION TECHNIQUE

1.00

Are individual Health Records in the custody of a medical treatment facility or maintained by an appointed Health Record Custodian? (AR 40-66, para 1-5b, para 5-3) (AU)

b. Army medical records, other than those of RCs, will remain in the custody of the MTFs at all times. RC records will remain in the custody of the appointed HREC custodian. The medical records of special operations forces will also remain in the custody of the MTFs at all times. This medical record is the Government's record of the medical care that it has rendered and must be protected. Upon request, the patient may be provided with a copy of his or her record, but not the original record. Only one free copy may be provided to the patient. Procedures should ensure conscientious Government control over medical records for good medical care, performance improvement, and risk management. Limit access to all open record storage areas and to electronic records to authorized personnel only. 5-3 HRECs will be prepared and maintained for all Army members. This includes Active Army and RC members, andcadets of the U.S. Military Academy. ARNGUS and USAR HRECs will be prepared and maintained by the custodian of the personnel files. (These HRECs will be prepared in accordance with paragraph 4–1, but they will be filed in alphabetical sequence.) When transferred to Army custody, HRECs for members of the Navy and Air Force will also be maintained. HRECs for military prisoners will be kept as long as they are confined in U.S. military facilities.

Check record custody procedures. In the case of RC units maintaining their Medical Records, ensure that the custodian is appointed on orders by the commander.

2.00

Are individual Health Records physically stored to ensure security and confidentiality of the records? (AR 340-21, para 4-4) (AU)

4–4. Safeguarding personal information *a.* The Privacy Act requires establishment of proper administrative, technical, and physical safeguards to—(1) Ensure the security and confidentiality of records. (2) Protect against any threats or hazards to the subject's security or integrity that could result in substantial harm,

embarrassment, inconvenience, or unfairness. *b.* At each location, and for each system of records, an official will be designated to safeguard the information in that system. Consideration must be given to such items as sensitivity of the data need for accuracy and reliability in operations, general security of the area, and cost of safeguards. (See AR 380–380.) *c.* Ordinarily, personal information must be afforded at least the protection required for information designated "For Official Use Only."(See AR340–17, chap IV.) Privacy Act data will be afforded reasonable safeguards to prevent inadvertent or unauthorized disclosure of record content during processing, storage, transmission, and disposal.

Check security of health records. In the case of RC units maintaining their Medical Records, ensure that only authorized personnel have physical access to the records.

*3.00

Is access to individual Health Records restricted to authorized personnel only? (AR 40-66, para 5-23) (AU)

5–23. Access to health records All personnel having access to HRECs will protect the privacy of medical information. (See chap 2.) The extent of access allowed to certain personnel is described in *a* through *e*, below. *a.* Medical personnel. AMEDD personnel are allowed direct access to HRECs for purposes of diagnosis, treatment, and the prevention of medical and dental conditions. They also have access to work for the health of a command and to do medical research. *b.* Military members. If a military member requests information from his or her HREC or copies of the documents in it, it will be given to him or her. If the record is a special category record, see AR 340–21, paragraph 2–5. However, the failure or refusal of a patient to designate a physician to receive information from his or her health record does not relieve the Army of the obligation to eventually provide the requested information to the patient. In this circumstance, competent medical authority will institute and adhere to appropriate procedures to ensure that the actual or perceived harm to the patient by disclosure of the health record is minimized. *c.* Inspectors. Personnel inspecting MTF, DENTAC, or USAR records are allowed direct access to HRECs. These personnel include Inspector General personnel conducting Nuclear Surety Program and Chemical Surety Program inspections in accordance with AR 50–5 and AR 50–6 (AR 20–1); it also includes Defense Nuclear Agency inspectors conducting Defense Nuclear Surety Inspections in accordance with AR 50–5. Inspectors may have access to HRECs to evaluate the compliance of AMEDD personnel with regulations. All inspectors must respect the confidentiality of the HRECs they inspect. Inspectors do not have unlimited access to ASAP–OMRs in accordance with 42 USC 290dd-2. *d.* Mortuary affairs personnel. Mortuary affairs personnel are allowed direct access to the HRECs of personnel killed or missing in action. They may have access to extract medical and dental information needed by their service. *e.* Other nonmedical Army personnel. Nonmedical personnel may need information from a person's HREC for official reasons. These personnel include unit commanders; inspectors general; officers, civilian attorneys, and military and civilian personnel of the Judge Advocate General's Corps; military personnel officers; and members of the U.S. Army Criminal Investigation Command or military police performing official investigations. Official requests for specific information from the HREC or copies of documents in it will be sent to the MTF Patient Administration Division, DENTAC commander, or RC record custodian, who will determine what information, will be supplied by the MTF. (See para 2–3*a*.) Persons designated as certifying and reviewing officials in accordance with the terms of the Personnel Reliability Program, in accordance with AR 50–5 and AR 50–6, are authorized to review medical records of candidates and members of the Personnel Reliability Program in conjunction with proper medical authorities. Access to ASAP–OMRs is limited. (See guidance in 42 USC 290dd-2.)

Check for restricted access to health records. In the case of RC units maintaining their Health Records, ensure that an access roster is signed by the commander and posted. Access must be limited to those authorized in AR 40-66, para 5-23e

4.00

Does the unit commander ensure confidentiality of individual Health Records and patient medical information? (AR 40-66, para 2-2) (AU)

2–2. DA policy mandates that the confidentiality of PHI of both living and deceased individuals will be ensured to the fullest extent possible. PHI will be disclosed only if authorized by law and regulation. *a.* Within DA, PHI may be used for treatment, payment, health care operations, and preventive care of patients. PHI may also be used within DA to monitor the delivery of health-care services, to conduct medical research, to provide medical education, to facilitate hospital accreditation, and to satisfy other official purposes.

b. Each Army MTF/DTF will give patients a copy of the Notice of Privacy Practices (NOPP). The NOPP explains to beneficiaries how their PHI may be used as well as their patient rights concerning PHI. Beneficiaries will sign the NOPP acknowledgment (para 4–4) showing that they received this notice. Note: A military prison inmate does not complete the NOPP acknowledgment. *c.* Unless authorized by law or regulation, no person or organization will be granted access to PHI. *d.* Any person who, without proper authorization, discloses PHI may be subject to adverse administrative action or disciplinary proceedings. Under HIPAA, penalties for misuse or misappropriation of PHI include both civil monetary penalties and criminal penalties. Civil penalties range from $100 for each violation to a maximum of $25,000 per year for the same violations. Criminal penalties vary from $50,000 and/or 1-year imprisonment to $250,000 and/or 10-years imprisonment (Sections 1320d-5 and 1320d-6, Title 42, United States Code). Report all possible violations of this regulation to the Privacy Officer and/or the commander, who will consult with the servicing legal office to determine a proper disposition for the reported violation. *e.* PHI is often viewed by clerical and administrative personnel, such as secretaries, transcriptionists, and medical specialists. This access is authorized and necessary in order for an MTF to properly process and maintain information and records. However, the MTF commander will ensure that all persons with access to PHI are trained in their obligation to maintain the confidentiality and privacy of PHI. Required training includes web-based program modules covering health information privacy laws and procedures for using or disclosing PHI. *f.* When PHI is officially requested for a use other than patient care, only enough information will be provided to satisfy the request.

Check local procedures to ensure confidentiality.

*5.00

For Active Duty units, are Health Record files screened semi-annually against current personnel rosters? (AR 40-66, para 5-28b (3)) (AU)

(3) HREC files for active duty personnel will be screened semiannually against current personnel rosters to ensure that the MTF file holds only the records of personnel served by that MTF. When an HREC or medical form is held by the wrong custodian, MTF records personnel will send the documents to the current custodian.

Check for the screening procedures. Verify that last screening was completed not more than six months previous.

6.00

Does the flight surgeon ensure health records of aviation personnel are maintained appropriately? (AR 40-3, Para. 3-5a(2)) (AU)

Para. 3–5a (2). Flight surgeon clinical duties. a. Primary care. The FS will— (2) Ensure appropriate maintenance of medical records on all aviation personnel, including air crewmembers in non-operational assignments even if not on active flying duty (on flight status). He or she will maintain a tracking mechanism to ensure aero medical documents such as FDMEs, DA Forms 4186, and so forth, arrive at their proper destinations. He or she will also ensure aviation medical records are included in all supervising MTF health record (HREC) quality assurance programs.

Check health records to determine completion and correctness. Verify that records are incorporated into a quality assurance program.

*7.00

Do individual Health Records contain **all required DA Forms 4186 and are they properly completed**? (AR 40-66, Para. 5-21b(6)) (AU)

Para 5-21b (6) DA Form 4186 (Medical Recommendation for Flying Duty). File the most recent DA Form 4186. If the person is granted clearance to fly, file the most recent DA Form 4186 next, if any, that shows a medical restriction from flying. If a waiver has been granted for any cause of medical unfitness for flying, file the most recent DA Form(s) 4186 showing such waiver(s) next. File any additional DA Forms 4186 that the flight surgeon determines to be required as a permanent record next. (Enter “Permanent Record” in Remarks section.) Destroy other DA Forms 4186.

Check for required DA Forms 4186 and verify ensure the form is filled out properly.

8.00

Does an aviation physician's assistant or non-flight surgeon, issue a DA Form 4186 to return a crewmember to flying duty only when a flight surgeon is not readily available, and is the DA Form 4186 properly annotated to confirm the flight surgeon giving the verbal or telephonic approval? (AR 40-501, Para. 6-11 j, k) (AU)

Para. 6-11, j. Personnel authorized to sign the DA Form 4186 are as follows. (1) Any physician or health care provider may sign DA Form 4186 for the purpose of restricting aircrew and ATCs from aviation duties when an aero medical DQ exists. (See b above and chap 4.) (2) Only an FS may sign the DA Form 4186 to return aircrew and ATCs to FFD. Recommended restrictions will be annotated in the Remarks block of DA Form 4186. (3) A non-FS medical officer or an APA under the supervision of an FS may sign the DA Form 4186 to recommend returning aircrew and ATCs to FFD when an FS is not locally available by either— (a) Obtaining case-by-case telephonic guidance from an FS. The name of the consulted FS will be annotated on DA Form 4186, and on an SF 600 (Health Record—Chronological Record of Medical Care) in the patient health record, according to AR 40–48. (b) In the case of an APA, having an FS review the medical record and cosign the DA Form 4186 within 72 hours. k. Forms of the other branches of the U.S. Armed Forces and host allied nations similar to DA Form 4186 will be accepted by the Army when aero medical support is provided by those Service and or nations and DA Form 4186 is not available.

In the case of an APA receiving a FS co-signature, ensure that the FS cosigns the DA Form 4186 within 72 hours. In the case of an APA receiving a case-by-case telephonic FS approval, ensure that the telephonic approval and the Flight Surgeon's name is mentioned in the remarks block of the DA Form 4186, and ensure that an SF 600 is posted in the Health Records noting the telephonic approval.

9.00

Does the Flight Surgeon interview newly assigned aviation personnel and review their medical records before granting a medical clearance to fly? (AR 40-3, para 3-5d(2)) (AU)

(2) Interview newly assigned aviation personnel and review their medical records before granting a medical clearance to fly.

Review the Flight Surgeon's procedures to see if the flight surgeon is interviewing all newly assigned crewmembers and reviewing their Health Records prior to issuing a DA Form 4186.

10.00

Are Aircrew members informing the Flight Surgeon when they have participated in activities or have received treatment following which there may be flying restrictions, and are these events documented on a DA Form 4186? (AR 40-8, para 3b, AR 40-501, para 6-11b) (AU)

b. Aircrew members will inform their flight surgeon when they have participated in activities or received treatment following which flying restrictions may be appropriate. 6-11b *b.* DA Form 4186 will be completed— (1) After the completion of an FDME. (2) After an aircraft mishap. (3) After an FEB. (4) When reporting to a new duty station or upon being assigned to operational flying duty. (5) When admitted to and discharged from any medical or dental treatment facility (inpatient or outpatient, military or civilian), sick in quarters, interviewed for or entered into a drug/alcohol treatment program, or when treated by a health care professional who is not a military FS or otherwise authorized to issue a DA Form 4186. (6) When treated as an outpatient for conditions or with drugs that are disqualifying for aviation duties; and upon return to flight duties after such treatment and recovery. (7) Upon return to flight status after termination of temporary medical suspension, issuance of waiver for aviation service, or requalification after medical or nonmedical termination of aviation service. (8) Other occasions as required by the FS or qualified aeromedical health care provider.

Check for **unit procedures to verify that aircrew members are informing the FS. Check Health Records for possible grounding medical conditions and ensure that a DA Form 4186 is used to document informing the FS.**

11.00

Does the Flight Surgeon medically clear air crewmembers for further flight duty following temporary medical disqualification or after an aircraft mishap? (AR 40-3, 3-5d (4)) (AU)

3-5d(4) Medically clear air crewmembers for further flight duty following temporary medical disqualification or aircraft mishap. (5) Ensure timely evaluation of aviation personnel who are medically disqualified.

Check records for **DA Forms 4186 showing medical clearance after a temporary medical disqualification or aircraft mishap.**

12.00

Are current extensions for flight physicals (FDME) filed in individual health records IAW AR 40-501, para. 6-11i? (AU)

Para. 6-11. i. The validity period of the current FDME (see para 6-8) may be extended for a period of 1 calendar month beyond the birth month on the DA Form 4186. After expiration of this extension, the aircrew member or ATC must complete the FDME and be medically qualified or be— (1) Administratively restricted from flying duties if no aeromedical DQ exists and be considered for a non–medical DQ and FEB (AR 600–105). (2) Medically restricted from flying duties if an aeromedical DQ exists. In some cases, temporary flying duties may be recommended on DA Form 4186. (See also *f*, above, and paras 6–12 through 6–21.)

Check health records for extension documentation.

13.00

Do individual Health Records contain medical waivers and suspension recommendations and approval letters as applicable? (AR 40-501, para 6-10g)(AU)

g. Disposal of documentation. Waiver and suspension recommendation and approval letters will be filed in the individual health record and flight record. 6-3. The forms and other documents used to maintain flight records are filed in DA Form 3513 (*Individual Flight Records Folder, United States Army*) (IFRF). Paragraph 6-4 discusses folder-labeling procedures for these forms. Figure 6-1 shows the recommended method of labeling. Table 6-1 shows retention requirements for DA Form 4186 (*Medical Recommendation for Flying Duty*). Table 6-2 shows how closeout forms are distributed. The following are used to maintain the IFRF (DA Form 3513)—

Check for applicable waivers requests and approval letters. Waivers printed from AERO with "Waiver Granted" will suffice in lieu of waiver request and approval letters.

14.00

Are Health Records filed alphabetically or in terminal digit order? (AR 40-66, para 5-28a) (AU)

a. HREC files. HRECs will be filed at the MTF or DTF (includes Family Health Center clinics authorized to provide primary care to active duty units and members) that provides military medical and dental care or with the RC health records custodian. If the member is assigned to an isolated unit without a servicing MTF or AMEDD personnel, the HREC will be filed at the unit under the custodianship of the commander. (See para 1–4*b*.) The records may be filed alphabetically or in terminal digit sequence. (See chap 4.) A chargeout system will be used when the HREC is temporarily removed from the record room. (See para 4–6.)

Check record filing system.

15.00

Are sign-out procedures established to maintain accountability of health records? (AR 40-66 Para. 4-6) (AU)

Para. 4–6. Record charge out system a. The current physical location or destination of each record must be known. A charge out folder will be put in the file when a record is removed for use. The type of folder used may be determined locally; however, DA Form 3444- series or DA Form 8005-series may not be used. (1) OF 23 (Charge-Out Record) or another charge out record will be put in the folder; this record will show where the medical record is located. If a charged-out record is later moved to another location, a "change-of-charge" must be submitted to the record custodian. (2) Any laboratory reports, x rays, or other reports that arrive while a record is charged out will be put in the folder until the record is returned. (3) Records will be charged out no longer than necessary. Records sent to in-house clinics will be returned the same day as the clinic visit. However, if the record is transferred to another clinic for a consultation the following day, a change-of-charge will be sent to the record custodian instead of the record. b. An automated record charge-out (CHCS) may be used to update a record tracking system (CHCS) using bar codes.

Check established procedures and ensure they are working.

16.00

Is a charge out folder put in the file when a Health Record is removed for use? (AR 40-66, 4-6a) (AU)

a. The current physical location or destination of each record must be known. A chargeout folder will be put in the file when a record is removed for use. The type of folder used may be determined locally; however, DA Form 3444-series or DA Form 8005-series may not be used.

Check sign out procedures. **Check to ensure that charge out folders are filed in lieu of signed out Health Records.**

17.00

Are procedures established for disposition of health records of personnel no longer assigned? (AR 40-66 Para. 5-28d (3)) (AU)

d. Handling stray records and forms. Stray records and forms found during the semiannual files review will be handled as described in (1) through (3), below. (1) The records and forms will be screened against the MTF or DTF files, including the suspense cards. Those files that can be identified (that is, matched with a record or suspense card) will be sent to the proper custodian. The letter of transmittal will cite the member's assigned unit. (2) When the proper custodians cannot be determined, the MTF or DTF will, if possible, access its Defense Enrollment Eligibility Reporting System (DEERS) MDRTS to obtain the current record custodian. Otherwise, the MTF or DTF will make a list of the members to whom the records belong, giving each member's full name, SSN, and current unit of assignment if possible. (It is a requirement of the world-wide locator service that both the full name and SSN be included.) The list will be sent to the MILPO with a cover letter requesting that the names be checked. The local MILPO should determine the appropriate section within its organization to complete the required action on the list. (Some installations have In/Out Processing Sections where installations' rosters and clearance files can be checked; at other installations, these functions are handled in the consolidation of military personnel activities.) After the MILPO has searched its files, the list should be forwarded to the post locator or to the installation activity that maintains the worldwide locator file. The MILPO or post locator response will be kept by the MTF or DTF in a file (file number 40 (general medical services correspondence files)) for 1 year. (See table 3–1.) (See AR 25–400–2 for information on nonaction paper files.)

Check to ensure disposition procedures are established and that no extraneous records are present.

18.00

Does the flight surgeon's office retain a copy of the FDME and all enclosures for a minimum of two years? (AR 40-501, Para. 6-10 c, d) (AU)

Para. 6–10. Disposition and review of FDMEs c. Classes 1/1A and Initial Classes 2/2F/2S/4. Completed FDMEs (originals of DD Form 2807–1, DD Form 2808, aeromedical continuation sheet, interpreted EKG, and other supportive documents) accomplished for application to aviation and aviation medicine training programs will be forwarded through the procurement chain of command of the applicant to Commander, USAAMC, ATTN: MCXY–AER, Fort Rucker, AL 36362–5333 for central aeromedical review and disposition. The FS's office will retain a copy of the FDME and all enclosures for a minimum of 2 years. In no case will the originals be given to the applicant or other individuals not in the procurement chain of command. The Commander, USAAMC must make a final determination of fitness for flying duties before Classes 1/1A/2F/2S/4 applicants may be accepted and assigned to Fort Rucker for aviation and aviation medicine training programs. d. Trained Classes 2/2F/2S/4. Completed Comprehensive and Interim FDMEs (DD Form 2808 and DD Form 2807–1, aeromedical continuation forms, interpreted EKG, and other supportive documents, may include consultations, EKG tracings, radiographs, coronary angiogram, etc., and, if applicable, Aeromedical Summary) will be forwarded directly to Commander, USAAMC, ATTN: MCXY–AER, Fort Rucker, AL 36362–5333, for central aeromedical review and disposition. The FS's office will retain a copy of the FDME and all enclosures for a minimum of 2 years.

Check to ensure the required records are maintained.

19.00

Does the Flight Surgeon recommend medical termination from aviation service (permanent medical suspension) if the term of temporary medical suspension has or is expected to exceed 365 days? (AR 40-501, para 6-17h) (AU)

h. The FS will recommend medical termination from aviation service (permanent medical suspension) if the term of temporary medical suspension has or is expected to exceed 365 days. The FS will notify the immediate commander by DA Form 4186 and forward an Aeromedical Summary to Commander, USAAMC, ATTN: MCXY–AER.

Determine if the unit has any crewmembers have been temporarily grounded for over 365 days. Verify that the FS has recommended a permanent medical suspension.

20.00

Are crewmembers completing FDMEs within 90 days of redeployment if they received incomplete "deployment" FDMEs while deployed? (AR 40-501, para 6-8d) (AU)

AR 40-501, Para 6-8d. The FDME will be completed to the extent the MTFs permit when aircrew are on duty or in mobilization at a station OCONUS with limited military medical facilities. Attach a cover letter to the FDME addressed to Commander, USAAMC, ATTN: MCXY-AER (USAAMA), explaining the facility limitations. Align subsequent Comprehensive or Interim FDMEs with the aircrew member's birth month using table 6-1.

Check records for completion of FDMEs within 90 days of redeployment.

C- AEROMEDICAL EVACUATION UNITS

1.00

Does a flight surgeon participate in the training air ambulance personnel? (AR 40-3, Para. 3-6d and Para. 3-6f (3), 13-3c(4) (AU)

Para. 3-6d Air ambulance operations. The FS will—Function as medical technical advisor to local air ambulance unit commanders and MTF commanders. This includes, but is not limited to, instructing medical evacuation personnel, reviewing reports of medical evacuations (run sheets) for appropriateness of the mission and the care given, and evaluating equipment taken aboard medical evacuation aircraft. Para. 3-6f(3) Participate in aircraft mishap exercises and observe the effectiveness of response, equipment, and communication of fire rescue, air ambulance, and medical teams. The FS will develop and periodically review the medical portion of the unit's pre-accident plan Para. 13-3c(4) Training of emergency medical technician (EMT) personnel shall be according to the Department of Transportation EMT National Standard Curriculum or equivalent to it and accepted by the National Registry for Emergency Medical Technicians (NREMT). EMTs working in pre-hospital EMS, to include both ground and air ambulance, shall possess and maintain current certification through the NREMT commensurate with the requirements of the positions to which currently assigned (that is, emergency medical technician-basic (EMT–B), emergency medical technician intermediate (EMT–I), emergency medical technician-paramedic (EMT–P)).

Check for evidence of flight surgeon participation in the required training.

2.00

Does the Flight Surgeon review reports of medical evacuations (run sheets) for appropriateness of the mission and care given? (AR 40-3, para 3-6d)

3-6d. Air ambulance operations. The FS will—(1) Function as medical technical advisor to local air ambulance unit commanders and MTF commanders. This includes, but is not limited to, instructing medical evacuation personnel, reviewing reports of medical evacuations (run sheets) for appropriateness of the mission and the care given, and evaluating equipment taken aboard medical evacuation aircraft.

Check for review of the run sheets.

3.00

Does the flight surgeon function as the medical technical advisor to the local air ambulance unit commander? (AR 40-3, para 3-6 (d))(AU)

d. Air ambulance operations. The FS will— (1) Function as medical technical advisor to local air ambulance unit commanders and MTF commanders. This includes, but is not limited to, instructing medical evacuation personnel, reviewing reports of medical evacuations (run sheets) for appropriateness of the mission and the care given, and evaluating equipment taken aboard medical evacuation aircraft. (2) Participate in actual air evacuation missions as appropriate.

Check for evidence of flight surgeon participation in the required training. **Look for evidence of FS involvement in Flight Medic training, reviewing run sheets, evaluation or providing training with aircraft medical equipment, and participation during air evacuation missions.**

4.00

Does the Flight Surgeon evaluate equipment taken aboard medical evacuation aircraft? (AR 40-3, para 3-6d)

d. Air ambulance operations. The FS will— (1) Function as medical technical advisor to local air ambulance unit commanders and MTF commanders. This includes, but is not limited to, instructing medical evacuation personnel, reviewing reports of medical evacuations (run sheets) for appropriateness of the mission and the care given, and evaluating equipment taken aboard medical evacuation aircraft. (2) Participate in actual air evacuation missions as appropriate.

Check for evidence of **the Flight Surgeon's evaluation of medical equipment taken on board the aircraft.**

5.00

Have the Medical Service Corps aviators (67J) successfully completed the Medical Evaluation Doctrine Course (2C-F7)? (DA Pam 611-21, para 3-21j (2)) (AU)

(2) *Special qualifications.* Must hold a baccalaureate degree from an accredited college/university in a discipline acceptable to The Surgeon General, be a graduate of the AMEDD Officer Basic Course and be selected for the Rotary Wing Aviator Course. Must successfully complete the Essential Medical Training for AMEDD Aviators Course (2C-F7 Course) and maintain qualifications for unrestricted utilization as an Aeromedical Evacuation Officer. Before entering the MAJ promotion window, officers must have successfully completed the AMEDD Officer Advanced Course and CAS3. To hold executive positions at the LTC and COL levels, must have successfully completed the U.S. Army CGSC and should possess masters degree from an accredited program acceptable to The Surgeon General in a discipline related to one of the AOC in the MFA 70. Specific duties and restrictions are referenced in table

Check for documentation (diploma, OER, etc.) that shows completion of 2C-F7 for each assigned 67J.

6.00

Have commissioned officers in the rank of 1LT or above who are transferring to Medical Service Corps billets (67J) completed the AMEDD Officers Branch Qualification Course (advanced) 081-22MS? (DA Pam 350-59, para 4-15) (AU)

4–15. AMEDD Officer Branch Qualification Course (Advanced) 081–C22MS *a. Objective.* To provide commissioned officers transferring to the AMEDD with AMEDD–specific instruction normally presented in the resident AMEDD OAC. *b. Eligibility.* Commissioned officers in the rank of first lieutenant or above who have transferred into, or are in the process of transferring into, the AMEDD and who have completed an officer advanced course in a branch other than AMEDD. *c. Curriculum.* 16 subcourses on interactive CDs. *d. Subcourses.* MD0420, MD0482, IS7038, IS8720, MD0446, MD0447, MD0400, MD0478, MD0413, MD0405, IS7033, MD0430, MD0431, MD0460, MD0408, MD0424.

Check for course qualification documentation.

7.00

Is SACMS-VT (Semi-annual Combat Medical Skills Validation Test) administered at least twice a year with a minimum of four months between record events? (TC 8-800, preface) (AU)

The Army Surgeon General has directed that all 91W's, Health Care Specialists must validate skills proficiency semi-annually. Therefore SACMS-VT will be administered at least twice a year, with a minimum of 4 months separating record events. Commanders may administer SACMS-VT more than twice a year, but they must indicate beforehand when results are intended for record purposes.

Check for completion of validation test. Ensure recorded events are at least 4 months apart.

8.00

Are all 91W military occupational specialty (MOS) recertifying in accordance with National Registry of Emergency Medical Technicians guidance? (AR 40-68, para 4-3a (2))

(2) In specialties that are not licensed by the State, and the requirements of the granting authority for State

registration or certification are highly variable, there must be validation by a national organization that the individual is professionally qualified to provide health care in a specified discipline. Examples of this are the National Commission on the Certification of Physicians Assistants (NCCPA) for physician assistants (PAs) and the National Registry of Emergency Medical Technicians (NREMT) for emergency medical technicians.

Check for NREMT certification on all assigned 91Ws. This can be verified using certification documents or using MODS.

9.00

Does the commander ensure accountability, control, safeguard, and maintenance of medical materiel? (AR 40-61, para 1-5)

1–5. Automation application The policies established in this regulation apply to manual and automated medical logistics operations. Proponents of automated systems being developed for fielding will comply with these policies. Activities operating under an approved automated supply system will use the automated procedures and capabilities of the automated system to satisfy the policies prescribed in this regulation. **1–6. Recordkeeping requirements** This regulation requires the creation, maintenance, and use of specific records, which are listed in table 1–1. (See AR 25–400–2 for file numbers (FNs), descriptions, and dispositions.)

Check the control procedures to **ensure that medical equipment is properly secured and accounted for and that shortages are properly requested and reported.**

10.00

Are medical equipment sets, kits, outfits, and tools (SKOT) for air ambulance operations accurately reported on the Unit Status Report? (AR 220-1, para 5-5)

5–5. Evaluating component part availability *a.* Reportable LINs having several components, for example, sets, kits or outfits (SKO) and/or medical materiel equipment sets (MMS/MES/DES/DMS/VES), will be reported as on-hand if property records show the LIN has been issued and at least 75 percent of each SKO non-expendable and durable items are present and serviceable. Do not count the set as on-hand, if more than 25 percent of the non-expendable and/or durable components are unserviceable, missing, depleted or require supply action under AR 735–5 (for example, report of survey). *b.* ALL RC units will exclude all expendable and durable MMS/MES/DES/DMS/VES component items that have a shelf life less than 60 months (shelf life codes of A–H, J–M, P–R or 1–9). AC, echelon III and IV medical units will exclude all expendable and durable items with a shelf life less than 60 months that are part of the Surgeon General's Centralized contingency programs. The list of this materiel is available in SB–8–75–S7 and can be accessed on http://www.armymedicine.army.mil/usamma.

Check the unit status report for accurate reporting of **medical equipment sets, kits, outfits and tools. Verify shortages by reviewing property book, hand receipt and turn in documents. If necessary, verify shortages by physical inspection. If component shortages of greater than 75% exist, review the USR for proper reporting.**

11.00

Are medical equipment sets, kits, outfits, and tools (SKOT) shortages identified and on a valid requisition? (AR 710-2, para 2-6)

2–6. Requesting supplies *a.* Commanders will ensure that equipment and components listed in the authorized column (of the MTOE and TDA) are on hand or on request. Where available, TAADS-based automated systems such as: Distribution Execution System (DES), Logistics Army authorization document system (LOGTAADS), SPBS–R, DPAS, and the SPBS–R/I TDA will be used to request MTOE/TDA items. For an ammunition basic load requested on a preapproved DA Form 581 (Request For Issue and Turn-In of Ammunition), but not on hand, the document number will be entered to the property book.

Verify shortages by reviewing property book, hand receipt and turn in documents. If necessary, verify shortages by physical inspection. Check for the requisitions and check with the ARMS team supply for their results of the unit supply evaluations.

12.00

Does the unit have a hoist maintenance SOP? (AR 750-1, para 3-6b)

3–6*b.* Standing operating procedures (SOPs) will be established and maintained by all Army organizations and activities performing maintenance operations.

Check with the ARMS maintenance evaluator or confirm a hoist maintenance SOP yourself.

13.00

Does the unit conduct required scheduled maintenance on its hoists? (TM 55-1680-320-23 and P, para 2-8 and table 2-1)

3-2. The Army Maintenance Standard. The Army has one maintenance standard. Army equipment meets the maintenance standard when the following conditions exist…(6) Scheduled services are performed at the service interval required by the applicable technical publication.

Check documentation to see if prescribed maintenance is being performed. **Use the hoist log book and/or historical records to verify that proper maintenance is being conducted. Ensure that hoist maintainers are certified through the Oregon NG RTI Hoist Maintenance Course or the Goodrich Hoist and Winch Course.**

14.00

Are log books properly maintained for each hoist? (DA Pam 750-8, para 5-10a-b)

5–10. Equipment log book binder *a.* Units keep all like historical forms in a binder (NSN 7510–00–889–3494). That is, all the units DA Form 2408–4 go in one binder. The units DA Form 2408–9 Transfer Reports go in one binder. When the combined forms are too large for one binder, they are divided into two or more binders. *b.* DA Form 2408–9 normally needs the following binders: (1) Acceptance or Gain Reports. (3) Usage Reports (Units with ULLS-G, this does not apply). (4) Repair Reports. *c.* Equipment logbook binders may also be used to hold forms required on a missile system while on dispatch when more forms are needed than can be kept in an equipment record folder. *d.* Units with six or fewer items of equipment may keep like forms in a binder or keep all the forms on an item of equipment in a binder *e.* USAMC activities may also keep all the forms on an APS item of equipment in a binder.

Check the log books or check with the ARMS maintenance evaluators to determine if proper documentation is maintained **for each hoist**.

15.00

Is the unit using up to date maintenance manuals for hoist maintenance (TM 55-1680-320-23 and P)? ? (FM 3-04.500, Para 8-16 thru 8-18). (AU)

FM 3-04.500, 8-16. QC and shop personnel establish and maintain a complete, up-to-date set of technical publications for supported aircraft. These publications provide instructions on procedures and issue, operation, maintenance, repair, modification, serviceability standards, testing, inspection, and storage of equipment. Publication personnel are appointed in the unit. They are responsible for ordering and maintaining the unit's publication

accounts. 8-17. Upon receipt of a new index, DA Pam 25-30 (published quarterly on CD), the TI reviews publication files (technical libraries) throughout the maintenance activity for completeness and currency. TI's also assist in preparing recommendations for changes to publications on DA Form 2028 or DD Form 173/3(OCR) (Joint Message Form [Blue]) (Cat I Deficiency Report only). The TI establishes and maintains a file of recommended changes (AR 25-400-2). 8-18. QC and shop personnel must have a technical data familiarization chart or computer printout to ensure that maintenance personnel are familiar with publications relevant to their duties. See Figures 8-4 and 8-5 for samples. All publications applicable to equipment maintained and names of maintenance personnel are listed. Personnel initial beside each publication to indicate their familiarity with that publication. As changes are received, post the change number and erase the initials. After reviewing each change, personnel initial the chart or printout again. Each shop maintains separate charts or printouts. TIs check the charts or printouts during publication review to ensure the following: • All publications used by the shop are listed. • All shop personnel are listed. • All personnel have initialed to indicate their understanding of the publications. • All changes are posted according to DA Pam 25-40.

Is a complete and up to date technical reference library maintained for assigned aircraft and hoists? (FM 3-04.500) Are all technical publications, regulations with current changes posted and or CD-ROM on hand? Maintenance manuals without current changes posted constitute an unsat. An organization that supports UH-60 helicopters must have primary manuals for the aircraft and installed equipment (avionics, hoist etc.) available and posted. Any obsolete, superceded, or rescinded manuals found constitute an unsatisfactory library. If electronic publications are used, reading and printing capability must be available. Verify unit personnel are able to use Electronic Media. If personnel are not able to use the program this results in a failure. Units with external hoists must have the appropriate aircraft TM with changes.